Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DME SOLUTIONS, LP 605 OVERLAND TRAIL SOUTHLAKE, TX 76092	MFDR Tracking #:	M4-09-A168-01
Respondent Name and Box #: INSURANCE CO OF THE STATE OF PA REP. BOX #: 19		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Our's is a reimbursement issue with Broadspire a Crawford Company for Claimant…Clam filed and received by the carrier 2/18/2009. Response to this filing was that we need to supply a product invoice and that charges should be included in hospital charges. We submitted the product invoice and asked for reprocessing on 5/5/2009, which was completed on 6/12/2009. The reason for denial was that the procedure code/bill type is inconsistent with the place of service. The customer service rep. states that these charges should be included in the hospital charges. This is our second denial… We disagree with the carrier's decision to deny payment on the L8680 and L8681 because they consider them to be global charges. At (d) of that same section we are to go by the Medicare standard for billing and coding. Observing the Medicare guidelines per TX workers comp regulations, we find no mention of these services being considered global or bundled…"

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $9,192.32
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…If it is determined any prior or interim payments by Carrier were for inappropriate care, are excessive or are otherwise not in accordance with law, Carrier request the Division order a refund…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
02/05/09	L8680	1 – 2	$0.00
02/05/09	L8681	1 – 2	$0.00
Total:			$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.402, titled *Ambulatory Surgical Center Fee Guidelines* effective on or after August 31, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "W1 – Workers' Compensation State Fee Schedule"; "112 – Payment adjusted as not furnished directly to the patient and/or not documented"; "5 – The procedure code/bill type is inconsistent with the place of service"; "868-111 – No reimbursement recommended as this service should be included in the hospital/ASC billing"; "900 – Based on further review, no additional allowance is warranted" and "975.640 – Nurse review in-patient hospital/supply house."
2. According to Division Rule at 28 Texas Administrative Code Section 134.402(g) a facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable, and 134.402(g)(1)(B) that states "include with the billing a certification that the amount billed represents the actual cost (the amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," ad shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled." The information submitted by the Requestor did not contain a written agreement between Physician Surgical Center of Fort Worth and the Requestor. Therefore, reimbursement cannot be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section. 134.1, 134.402
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor III Medical Fee Dispute Resolution	August 21, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.